MEDI-CAL UPDATE Part 2
Billing and Policy
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2005 CPT-4/HCPCS Updates: Implementation November 1, 2005

The 2005 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2005. Specific policy changes are highlighted below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

ANESTHESIA

New anesthesia CPT-4 code 00561 (anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, under one year of age) may be reimbursed only for children younger than 1 year of age. Claims for code 00561 require both the anesthesia start and stop times and the appropriate anesthesia modifier.

SURGERY

Duplicate Payment: Combination Codes

Reimbursement will be made for only one code or set of codes in the following combinations when billed for the same date of service, any provider:

- G0364 vs. 38220 – 38221
- 11008 vs. 11000 – 11001, 11010 – 11044
- 19296 vs. 19160, 19162
- 27412 vs. 20926, 27331, 27570
- 29866 vs. 29870 – 29871, 29874 – 29875, 29877, 29884 (same session*) **or**
  29866 vs. 29879, 29885 – 29887 (same compartment*)
- 29867 vs. 27415
- 29867 vs. 27570, 29870 – 29871, 29874 – 29875, 29877, 29884 (same session*) **or**
  29867 vs. 29879, 29885 – 29887 (same compartment*)
- 29868 vs. 29870 – 29871, 29874 – 29875, 29880, 29883 – 29884 (same session*) **or**
  29868 vs. 29881 – 29882 (same compartment*)

***** Documentation is required in the *Reserved For Local Use* field (Box 19) of the claim to justify a different session and/or different compartment if billing code 29866, 29867 or 29868 with other codes listed.

- 31545/31546 vs. 31540, 31541, 69990
- 31546 vs. 20926
- 32019 vs. 32000 – 32005, 32020, 36000, 36410, 62318 – 62319, 64450, 64470, 64475
- 36475/36476 vs. 36000 – 36005, 36410, 36425, 36478, 36479, 37204, 75894, 76000 – 76003, 76937, 76942, 93970 – 93971
- 36478/36479 vs. 36000 – 36005, 36410, 36425, 36475 – 36476, 37204, 75894, 76000 – 76003, 76937, 76942, 93970 – 93971

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

Duplicate Payment: Combination Codes *(continued)*

- 36818 vs. 36819 – 36821, 36830 (during unilateral upper extremity surgery)
- 36819 vs. 36818, 36820, 36821, 36830 (during unilateral upper extremity surgery)
- 43644 vs. 43846, 49320
- 43645 vs. 49320, 43847
- 43845 vs. 43633, 43847, 44130, 49000
- 45391/45392 vs. 45330, 45341 – 45342, 45378, 76872
- 58356 vs. 58100, 58120, 58340, 76700, 76856
- 58956 vs. 49255, 58150, 58180, 58262 – 58263, 58550, 58661, 58700, 58720, 58900, 58925, 58940
- 63050/63051 vs. 22600, 22614, 22840 – 22842, 63001, 63015, 63045, 63048, 63295 (same segments)
- 63295 vs. 22590 – 22614, 22840 – 22844, 63050 – 63051 (same segments)
- 66711 vs. 66990

Reimbursement Restrictions for Select CPT-4 Surgery Codes

The following surgery codes have reimbursement restrictions as noted:

Codes 19296 – 19298, 29866, 29867, 29868, 31620, 31636, 31637, 31638, 32019, 45391 and 45392 are not reimbursable for assistant surgeon services.

Codes 36475, 36476, 36478, 36479, 43644, 43645, 43845 and 58956 require prior authorization.

Codes 37205 – 37208 are Medi-Cal benefits and require prior authorization.

Code 52402 is reimbursable for males only. This code is not reimbursable for assistant surgeon services.

Code 57267 is reimbursable for females only.

Codes 57283 and 58565 are reimbursable only for females 21 years of age or older.

Add-On Codes

The following CPT-4 codes are add-on codes and must be billed on the same claim with the corresponding code for the primary procedure:

Add-On Code	Primary Procedure Code(s)
11008	11004 – 11006
19297	19160 or 19162
31620	31622 – 31638
31637	31636
36476	36475
36479	36478
37206	37205
37208	37207
57267	45560 or 57240 – 57265
63295	63172 – 63173, 63185, 63190 or 63200 – 63290

Note: These add-on codes are not subject to the multiple surgery rate reduction pricing methodology when billed with the primary service code.

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

SURGICAL SERVICES

New HCPCS codes C9718 and C9719 (kyphoplasty) are Medi-Cal benefits.

New HCPCS code G0364 (bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service) is reimbursable to non-physician medical practitioners, but is not reimbursable for assistant surgeon services.

If CPT-4 codes 36818 and 36819 are billed for bilateral upper extremity open arteriovenous anastomoses performed at the same surgical session, providers must bill with modifier -50 (bilateral procedure) or -59 (distinct procedural service), as appropriate.

New CPT-4 codes 37215 (transcatheter placement of intravascular stent[s], cervical carotid artery, percutaneous; with distal embolic protection) and 37216 (without distal embolic protection) are Medi-Cal benefits and require prior authorization, subject to the following criteria:

- High-risk patient with symptomatic narrowing of carotid artery of 70 percent or more, **or**
- Patient at high risk for carotid endarectomy that has symptomatic carotid artery stenosis between 50 and 70 percent, **or**
- Asymptomatic high-risk patient with carotid artery stenosis of 80 percent or more.

Codes 37215 and 37216 are limited to providers and facilities that have been determined competent by the Centers for Medicare & Medicaid Services (CMS) to perform the appropriate evaluation, stent procedure and necessary follow-up care. Providers will be required to submit documentation with the claim that the facility is currently on the CMS list of approved facilities.

RADIOLOGY

Deleted and Replacement CPT-4 Codes

The following are deleted CPT-4 codes and their 2005 replacement codes. The policy of the deleted code applies to the replacement code(s).

Deleted Code(s)	Replacement Code(s)
78810	78811 – 78816
79020, 79030, 79035	79005
79100, 79400	79101

Codes Requiring Split Bill Modifiers

The following CPT-4 radiology codes are split-billable and must be billed with the appropriate modifier (-26, -TC, -ZS or -99): 75960, 76510, 76820, 76821, 78811 – 78816, 79005, 79101 and 79445.

Reimbursement Restrictions for Select CPT-4 Radiology Codes

Radiology code 75960 (transcatheter introduction of intravascular stent[s]) is a new benefit and requires prior authorization.

Code 76077 will not be a Medi-Cal benefit.

Reimbursement for fetal Doppler velocimetry, CPT-4 codes 76820 (umbilical artery) and 76821 (middle cerebral artery), is limited to once in 180 days, but second and subsequent claims may be reimbursed if documentation justifies medical necessity. Code 76820 must be billed with ICD-9 diagnosis codes 656.50 – 656.53 (poor fetal growth). Code 76821 must be billed with diagnosis codes 656.10 – 656.23 (excessive fetal growth). These codes may not be reimbursed to Alternative Birthing Centers.

Positron Emission Tomography (PET) scans are reimbursable only when billed with CPT-4 codes 78459, 78608, 78609 and 78811 – 78816. These codes are split billed and require a modifier. Providers must receive prior authorization for both the professional and technical component before billing for a PET scan. Only one of these codes may be reimbursed to any provider for the same recipient, same date of service.

Please see **CPT-4/HCPCS**, *page 4*

CPT-4/HCPCS *(continued)*

Duplicate Payment: Combination Codes
Reimbursement will be made for only one code or set of codes in the following combinations when billed for the same date of service, any provider:

- 79101 vs. 36400, 36410, 79403, 90780, 96408
- 79445 vs. 96420

PATHOLOGY
Codes Requiring Split-Bill Modifiers
The following CPT-4 pathology codes are split billable and must be billed with the appropriate modifier (-26, -TC, -ZS or -99): 82045, 85656, 83009, 83630, 84163, 84166, 86064, 86335, 86379, 86587, 87807 and 88360.

New CPT-4 code 87807 (infectious agent antigen detection by immunoassay with direct optical observation; respiratory syncytial virus) is a Clinical Laboratory Improvement Amendments (CLIA)-waived test when billed with modifier -QW (CLIA-waived tests).

New CPT-4 pathology codes 88184 – 88185 (flow cytometry, cell surface) are 100 percent technical services and must be billed with modifier -TC (technical component).

New CPT-4 pathology codes 88187 – 88189 (flow cytometry, interpretation) are 100 percent professional services and must be billed with modifier -26 (professional component).

DRUGS, INJECTIONS
New HCPCS Codes
The following new HCPCS codes are Medi-Cal benefits:

Code	Description
J0135*	Adalimumab, 20 mg
J2357*	Omalizumab, 5 mg
J2794*	Risperidone, long acting, 0.5 mg
J3396**	Verteporfin, 0.1 mg

* Codes J0135, J2357 and J2794 require prior authorization.

** Claims for code J3396 must be billed in conjunction with ICD-9 diagnosis code 362.52 (exudative senile macular degeneration). Providers must document in the *Reserved For Local Use* field (Box 19) of the claim both the Body Surface Area (BSA) of the recipient and the dose administered. Code J3396 must be billed in quantities of either 150 (15 mg) or 300 (30 mg).

MEDICINE
Duplicate Payment: Combination Codes
Reimbursement will be made for only one code or set of codes in the following combinations when billed for the same date of service, any provider:

- 92620, 92621 vs. 92506
- 92625 vs. 92562
- 93745 vs. 93741 – 93742
- 93890 – 93893 vs. 93886, 93888

Reimbursement Restrictions for Select Medicine Codes
CPT-4 codes 92620 and 92621 (evaluation of central auditory function, with report) and 92625 (assessment of tinnitus) require prior authorization.

New CPT-4 Transcranial Doppler codes 93890, 93892 and 93893 are limited to four procedures each, per year, and are restricted to the following ICD-9 diagnosis codes: 282.6 – 282.69 (sickle cell disease), 348.8 (other conditions of the brain), 430 (subarachnoid hemorrhage) and 433.00 – 433.91 (occlusion and stenosis of pre-cerebral arteries).

New CPT-4 codes 95928 and 95929 (central motor evoked potential studies) are limited to a total for both codes of four procedures, per year.

Please see **CPT-4/HCPCS**, *page 5*

CPT-4/HCPCS *(continued)*

ACUPUNCTURE

Deleted and Replacement CPT-4 Codes

The following are deleted CPT-4 acupuncture codes and their 2005 replacement codes.

Deleted Code	Replacement Codes
97780	97810, 97811
97781	97813, 97814

Duplicate Payment: Combination Codes

Reimbursement will be made for only one code or set of codes in the following combinations when billed for the same date of service, any provider:

- 97810 and 97811 vs. 97813 and 97814

Add-On Codes

The following CPT-4 codes are add-on codes and must be billed on the same claim with the corresponding primary service code:

Add-On Code	Primary Service Code
97811	97810
97814	97813

Reimbursement Restrictions

Acupuncture codes 97810, 97811, 97813 and 97814 require a Medi-Service Reservation and are reimbursable to podiatrists. One Medi-Service Reservation may include the following:

- One (1) unit of 97810 and up to two (2) units of 97811 or
- One (1) unit of 97813 and up to two (2) units of 97814, as appropriate

Reimbursement for each of these codes is $5.79 (per 15 minutes).

VACCINES FOR CHILDREN PROGRAM

New CPT-4 code 90656 (influenza vaccine [for recipients 3 years of age and older]) is reimbursable under the Vaccines For Children (VFC) program and must be billed with modifiers -SK (high risk) and -SL (state supplied vaccine).

CPT-4 code 90700 (DTaP vaccine) is now restricted to recipients younger than seven years of age.

COCHLEAR IMPLANT SUPPLIES

New HCPCS codes L8615 – L8618 require prior authorization.

HCPCS codes L8621 and L8622 (batteries) will not be Medi-Cal benefits.

Conversion of Interim Modifiers and Notice of Public Comment Period

HIPAA mandates that national modifiers replace interim HCPCS modifiers for use in Medi-Cal billing. Effective for dates of service on or after November 1, 2005, interim modifiers -YQ, -YS, -ZK, -ZU and -ZV will be replaced with new national modifiers as indicated below.

A public comment period is ongoing until September 30, 2005. (See below for more details.) Absent any grave concerns arising from the public comments, the Department of Health Services (DHS) will proceed with the modifier changes listed below. The policy of the interim modifier applies to the replacement modifier.

Please see **Conversion of Modifiers**, *page 6*

Conversion of Modifiers *(continued)*

Interim Modifier	Replacement National Modifier
-YQ (Certified nurse midwife service)	-SB (Nurse midwife)
-YS (Nurse practitioner service)	-SA (Nurse practitioner with physician)
-ZK (Primary surgeon)	-AG (Primary surgeon)
-ZU (Exception modifier to 80 percent reimbursement [medical necessity; outpatient setting])	**Two modifiers required:** -22 (Unusual procedural services) **and** -SC (Medically necessary service/supply) **and** Facility Type Code 13 or 83 **or** Facility Type Code 14 **plus** Frequency Code 1
-ZV (Exception modifier to 80 percent reimbursement [non-hospital compensated physician; emergency service])	**Three modifiers required:** -22 (Unusual procedural services) -SC (Medically necessary service/supply) -ET (Emergency services)

Note: When billing for the exception to 80 percent reimbursement, modifier -22 must be the first modifier listed on both the *Treatment Authorization Request* and claim form in order for the claim to reimburse correctly.

Comment Period

Notice is hereby given that DHS will conduct written public proceedings, during which time any interested person or such person's duly authorized representative may present statements, arguments or contentions (hereafter referred to as "comments") relevant to the action described in this notice.

Comments must be received by DHS by 5 p.m. on September 30, 2005, which is hereby designated as the close of the written comment period. All written comments to DHS, including e-mail, mail or fax transmissions, must include the author's name, organization or affiliation and telephone number.

Comment Instructions

The Medi-Cal Comment Forum page includes links for e-mail comments by "Providers," "Medi-Cal Managed Care Plans" or "General Public." The "Medi-Cal Comment Forum" page is located in the HIPAA News section on the Medi-Cal Web site (**www.medi-cal.ca.gov**). Providers should select the "Medi-Cal Comment Forum" link, enter comments in the body of the e-mail and send it to the pre-formatted address in the "To:" line.

Note: E-mail is not confidential, so users should be cautious when entering confidential or sensitive information. Email addresses will not be shared with outside parties, but may be used for future DHS mailings.

Comments may also be submitted by mail or fax to:

Medi-Cal Comment Forum
P.O. Box 13811
Sacramento, CA 95853
Fax: (916) 638-8976

All written comments to DHS, including e-mail, mail or fax transmissions, must include the author's name, organization or affiliation and telephone number.

Health plans are requested to centralize their comments and send them to DHS through their designated HIPAA contact person.

HIPAA Code Conversion for Respiratory Care Practitioners

Effective November 1, 2005, billing codes for respiratory care practitioners will be revised in compliance with HIPAA. The following interim HCPCS codes will be terminated:

- X4700 (respiratory care evaluation)
- X4702 (respiratory care case conference)

Respiratory care practitioners must now bill for their services with the following Evaluation and Management CPT-4 codes:

- 99202 (office visit, new patient, level 2)
- 99212 (office visit, established patient, level 2)

Code 99202 may be billed by a respiratory care practitioner once every three years, however, the recipient must not have been seen for any reason during the preceding three-year period by the same respiratory care practitioner.

Code 99212 may be billed by a respiratory care practitioner once in six months by the same provider, for the same recipient, with prior authorization.

Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update*.

Additional Laboratory Procedures Requiring Modifier -QW

Effective for dates of service on or after October 1, 2005, the following CPT-4 codes must be billed with modifier -QW (CLIA waived tests):

CPT-4 Code	Description
84443	Thyroid stimulating hormone (TSH)
84450	Transferase; aspartate amino (AST) (SGOT)
85576	Platelet, aggregation (in vitro) each agent
86703	HIV-1 and HIV-2, single assay

Modifier -QW indicates that the provider is certifying that a specific test kit from manufacturers identified by the Centers for Medicare and Medicaid Services (CMS) was used when performing the test. Failure to bill these codes with modifier -QW will result in the claims being denied.

For more information about laboratory procedure code proficiency testing or waived tests, refer to the *Pathology: An Overview of Enrollment and Proficiency Testing Requirements* section in the Part 2 manual.

This information is reflected on manual replacement pages modif app 3 (Part 2) and path bil 6 and 7 (Part 2).

Positron Emission Tomography Scan Benefit Update

Effective for dates of service on or after October 1, 2005, reimbursement guidelines for Positron Emission Tomography (PET) scans when billed with CPT-4 code 78810 (tumor imaging, positron emission tomography [PET], metabolic evaluation) will be expanded to include the initial staging and restaging of cancer of the cervix.

Reminder: Reimbursement for CPT-4 code 78810 requires a *Treatment Authorization Request* (TAR) for medical documentation or the claim will be denied.

The updated information is reflected on manual replacement page radi nuc 3 (Part 2).

Updated Secondary Diagnosis Codes for Incontinence Supply Products

Effective October 1, 2005, the following new and updated ICD-9 codes will be accepted as the secondary diagnosis for incontinence supply products:

ICD-9 Code	Description
788.30	Urinary incontinence, unspecified
788.31	Urge incontinence
788.32	Stress incontinence, male
788.33	Mixed incontinence (male) (female)
788.34	Incontinence without sensory awareness
788.35	Post-void dribbling
788.36	Nocturnal enuresis
788.37	Continuous leakage
788.39	Other urinary incontinence

Also, ICD-9 code 300.11 (conversion disorder) is removed from the list of acceptable secondary diagnosis codes.

Note: The following codes continue to be accepted as the secondary diagnosis for incontinence supply products:

ICD-9 Code	Description
307.6	Enuresis (non-organic)
307.7	Encopresis (non-organic)
787.6	Incontinence of feces
788.3	Incontinence of urine

The updated information is reflected on manual replacement page hcfa comp 13 (Part 2).

Revised Instructions For Billing CPT-4 Code 67040

Effective for dates of service on or after October 1, 2005, providers are no longer required to submit an invoice when billing for CPT-4 code 67040 (vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation). CPT-4 code 67040 is payable to both surgeon and assistant surgeon. Providers must continue to bill code 67040 with the appropriate surgical modifier.

The updated information is reflected on manual replacement page surg eye 1 (Part 2).

Important CLIA Reminder

Only a provider with a *Clinical Laboratory Improvement Amendment* (CLIA) certificate and state license or registration appropriate to the level of tests performed may be reimbursed for laboratory procedure codes.

CPT-4 Procedure Codes and Modifiers Billing Reminder

Providers are reminded that they must select the appropriate CPT-4 code and modifier when billing. The CPT-4 code descriptor must match the procedure performed.

This information is reflected on manual replacement page hcfa comp 16 (Part 2).

Primary Care Clinics May Apply for PE Participation

As a result of AB 2307 (Chapter 1, Statutes of 2004 [effective July 1, 2005]), Primary Care Clinics (PCC) may apply for participation in the Presumptive Eligibility (PE) program for pregnant women while waiting to be determined as a Medi-Cal provider. To accommodate these providers, Part 1 of the *Qualified Provider Application for Presumptive Eligibility Participation/Presumptive Eligibility Qualified Provider Responsibilities and Agreement* form (MC 311, revised 7/05) now includes a checkbox choice that allows PCC with no Medi-Cal number to apply for PE participation. The updated MC 311 is available on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "Forms" link. For general information about the PE program, see the Medi-Cal Web site and click "Presumptive Eligibility" under the "Specialty Programs" heading.

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The next orientation session is scheduled for October 20, 2005.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Session below.

October 20, 2005
The Westin Horton Plaza San Diego
910 Broadway Circle
San Diego, CA 92101
For directions, call
(619) 239-2200

Registration
Call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session listed in this article. Providers must supply the following:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Please see **Family PACT**, *page 10*

Family PACT *(continued)*

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present their:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers will not receive a certificate.

Contact Information
For more information regarding the Family PACT Program, please call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

FFS/MCN Information Removed from Manual

Fee-for-Service/Managed Care Network (FFS/MCN) pilot program information is being removed from the provider manual. FFS/MCN was terminated effective for dates of service on or after July 1, 2003. Information about the program, which consisted of Placer County Managed Care Network (Health Care Plan [HCP] 640) and Sonoma County Partners for Health Managed Care Network (HCP 642), was retained in the provider manual for a period of two years to help providers with final billing.

Providers should remove pages mcp ffs bil 1 thru 5 (Part 2) from their manuals.

Inpatient Provider Cut-off Date for Proprietary and Non-HIPAA Standard Electronic Claims Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal has established a plan to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claims transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cut-off dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Medi-Cal List of Contract Drugs

The following provider manual section has been updated: Drugs: Contract Drugs List Part 1 – Prescription Drugs.

Changes, effective September 1, 2005

Drug	**Size and/or Strength**
MESALAMINE	
Rectal suppositories	500 mg
	1000 mg
URSODIOL	
Capsules	300 mg
Tablets	250 mg
	500 mg

Change, effective November 1, 2005

Drug	**Size and/or Strength**
***** LATANOPROST	
Ophthalmic solution	0.005%

*** Prior authorization always required.**

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for General Medicine Services Billing and Policy v/vi* *****
	allergy 3 *
	cal child bil 1/2 *
	hcfa comp 13 thru 16
Remove the section *MCP: Fee-For-Service/ Managed Care Network (FFS.MCN) Billing Guidelines*:	mcp ffs bil 1 thru 5
Remove and Replace:	modif app 3/4
Remove:	path bil 5 thru 8
Insert:	path bil 5 thru 9 *(new)*
Remove and replace after the end of the *Presumptive Eligibility* section:	*Qualified Provider Application for Presumptive Eligibility Participation/Presumptive Eligibility Qualified Provider Responsibilities and Agreement* (MC 311)
Remove and Replace:	radi nuc 3
	surg eye 1

* Pages updated due to ongoing provider manual revisions.